Early Adopter/Full Integration Work Group
Work Plan

Issue/Concern/Request	Category	Resolution Ideas Opportunities

Financial integration does not mean clinical integration. How do we ensure a model that leads to clinical service delivery integration and better outcomes for clients?	Clinical	Principles/key components of integrated clinical care identified:
		
		• Provide flexibility in models: Integrated clinical care can happen anywhere – primary care, behavioral health, community settings
		  o Multiple models can achieve integration, examples include:
		  Co-location where appropriate
		  Full service provider
		  Unique collaborative relationships that aren't co-located
		  o Ensure models that include bi-directional care (PC in BH and BH in PC)
		• Ensure continuity of care (keeping provider, keeping meds)
		• Ensure a robust, interoperable data system: real-time sharing of data is critical for care coordination (a functional HIE that avoids data entry duplication)
		  o Single, shared care plan
		  o Single problem list
		  o Single medication list
		• Care coordination is a key component of integrated care model
		  o There are many levels of care coordination
		  o Some high needs recipients need face to face, outreach
		  o The committee would like to define a floor requirement for care coordination by plans
		• No wrong door – there should be basic screening (contrasted with assessment) at any portal (PC, MH CD) with accountability for referral and warm handoff
		• Language and cultural competency
		• Outreach is an expectation and is compensable
		• Peer support services are integral to the service delivery model
		• Care is team-based and includes a broad range of disciplines

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		• The system is outcome-driven and assures and ability to track outcomes and create accountability across systems and organizations • An integrated system is person-centered and driven by the needs and preferences of clients served
What does seamless and access look like?	Clinical	• Develop strategies that support an assisted referral and mechanisms of accountability to ensure a linkage happened o Examples include: supportive, warm hand off from one provider to another; transporting client; data systems that flag when a follow up appointment did not occur etc. Access looks like: • Adequate provider network under contract with adequate rates including paypoints necessary to effectively deliver integrated care • Clients and patients get into providers within a timely manner (as specifically benchmarked and measured by service, i.e. psychiatry with flexibility built in considering capacity within the system)
Need to emphasize face to face care coordination (vs. telephonic)	Clinical	Define levels of care coordination (reference Duals demonstration project contract as a potential model, based on health home model) that include high touch, face to face care coordination with clients with the highest, most complex needs
Are there other benefits that might be added to improve outcomes, gain efficiency and effectiveness of the service system	Clinical	Key services: • MH benefit for people who don't meet access to care should have access to the full continuum of care available through the Medicaid benefit including: full range of assessment and screening, individual and group therapy, medication evaluation and management, case management, peer support functions, community-delivered services, etc. • CD benefit should include a full continuum of services as detailed by the CD Integration Work Group

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		• Recovery support services are an essential part of the continuum • A multi-disciplinary Care Team Approach must be available and funded • Outreach, engagement, screening, and referral needs to include outreach and pre-intake engagement and be compensable • Consultative models (telemedicine, tele psychiatry) • Interpreter services • Transportation services
How do we support clinical models that include/allow for bi-directional care (PC in BH and BH in PC)	Clinical	• Education and outreach to primary care and behavioral health about various models and access to resources • Screening in all locations (medical in BH, BH in medical) • Require that plans are able to support multiple models of bi-directional integration and don't rule out any of them.
How do we ensure a payment model that allow for bidirectional integration (BH in PC and PC in BH)?	Finance	• Look at agreements with CMS regarding billing codes for same day services provided within mixed delivery settings (need to reference HIC/PIC and CPT codes to address specific barriers to same day services reimbursement under capitation) • Operationalize value-based funding • Create payment models that supports seeing BH clients because they take more time, no show more often, are more complex (i.e. actuarial rates for clinics that have established integrated care/primary care enhancement payments, etc) • Require that plans are able to support multiple models of bi-directional integration and don't rule out any of them.

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Local resources – counties bring significant local dollars and match money toward MH and CD services; how do we ensure services funded by Medicaid are integrated with locally funded services? How can it be used to best compliment the system in full integration?	Finance	Develop strategies to ensure coordination between managed care plans and local counties, philanthropy, and other funders to assist with aligning resources toward common goals/outcomes
Payment models for co-occurring disorders treatment	Finance	Do an across system look across primary care, CD, MH to do actuarial work to determine what co-occurring treatment costs are and project the population to be served and the mechanism to reevaluate population needs and rates in a timely manner.
Payment for services delivered in integrated care settings	Finance	
How are the CD capitated rates determined and do they cover the full needed benefit (not just what is currently delivered)	Finance	
Need to look at where costs are and who is at risk for those costs – how do we shift the financial incentives within the systems to support health and well-being? Need to create models that share risk across sectors so that everyone has skin in the game	Finance	
Integration and coordination of Crisis Services and ITA for MH and CD – Where will these services sit	Program	

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– MH ITA is County responsibility by law		
Coordination with State Hospitals – how will these be paid for in new model given Medicaid can't pay for state hospital stays; also discharge and transition services back to community are paid for with non-Medicaid and/or local dollars; caution about putting incentives in the right place to avoid cost shifting	Program	
Integration and coordination with Offender Reentry and Community Safety (ORCS) – funded outside of Medicaid	Program	
Integration/coordination with other specialty programs such as PACT, E&T, detox, residential, supported employment, etc.	Program	
TR law suit for children's mental health services; how will full integration be impacted by the settlement and changes to children's mental health	Program	
Federal Block Grant – where does that fit? MH & CD block grant dollars used differently	Program	
CD Prevention Services – currently paid for with non-Medicaid dollars	Program	

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Medicaid Personal Care – how will this be integrated and paid for in full integration model?	Program	
Diversion services currently funded with non-Medicaid dollars and/or local money	Program	
Integration and coordination with Residential Services (both MH and CD)	Program	
Supported Housing – how is paid for and supported	Program	
There needs to be a process in place to ensure that the full integration model is reducing health disparities in the region	Performance Monitoring	
Ensuring adequate level of outreach, engagement, screening and referral services to identify populations in need of specific services, especially most vulnerable SMI, homeless, etc.	Performance Monitoring	
Counties are concerned that client/provider complaints will not be adequately resolved in a timely fashion and such complaints will be brought to the county (thru executive and/or legislative branch). Counties (and RSAs and/or ACHs) need a role in quality	Performance Monitoring	

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assurance and monitoring, need access to data, process that they are involved in for complaint investigation and resolution.		
Clients who don't receive adequate services will end up in jail or other county funded services.	Performance Monitoring	
Baseline utilization in each service area needs to be identified and then monitored. What if it drops but money doesn't? Will we be able to determine why?	Performance Monitoring	
How to manage clients who border RSA's and may want to access services in another region?	Performance Monitoring	
What is the role of the ACH in achieving the desired outcomes?	Performance Monitoring	
How do we measure integration?	Performance Monitoring	
42 CFR Requirements around CD creates barriers to integration	Regulatory	
Work Force development – full integration creates need for new types of positions (care coordination/peer support/community health workers, as well as the need to	Regulatory	

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ensure current staff are trained to provide integrated care Also need training capacity in EBPs • College & University Training • Current Work Force Training		
Consolidating and/or standardizing WACs for MH, CD and Medical	Regulatory	
IMD issues – who is at risk and pays for stays in an IMD – how do we reduce cost shifting	Regulatory	
Health Information Exchange – includes sharing information across providers; client registries for care coordination	Data	
Who owns data, has access to data, etc.	Data	
Concerned that timelines are too aggressive and communities and providers may not be ready to make the shift that quickly	Process	
Ensure the state allows some flexibility in regional models to ensure the best clinical model for a community/beneficiaries	Process	
Role of client voice, advisory boards, patient engagement strategies	Process	

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Tribes		
Issues of cultural and linguistic competence		
• Uninsured, underinsured (who do you see and how do you get paid for serving them?)		